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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27862

State File No.

FILED SEP 10 1941 85

Registration District No.

Primary Registration District No. 1001

Registrar's No.

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1010 Henry
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 d 2
(Specify whether
In this community 22 Years
years, months or days)

3. (a) PRINT FULL NAME JOSEPH H. LAWRY

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife Delphina Lawry 6. (c) Age of husband or wife if alive years
7. Birth date of deceased May 19 1849
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
92 3 11 hr. min.

9. Birthplace Unknown Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business Butcher

12. Name William Lawry

13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Williams
(City, town, or county) (State or foreign country)

15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Minnie D. Hill.

(b) Address 2102 Francis St Joseph, Mo.

17. (a) Removal (b) Date thereof 9--1--41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest City, Mo.

18. (a) Signature of funeral director FLEEMAN & SON INC.

(b) Address St. Joseph, Mo.

19. (a) 8/31/41 (b) H. F. Mundy
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 2102 Francis
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 30th.
year 1941 hour 8 minute 00 P.M.

21. I hereby certify that I viewed the deceased from on
Aug 31 1941 to 19;
that I last saw him on 19;
and that death occurred on the date and hour stated above.

Immediate cause of death.

Chronic Myo Carditis 2 yrs
Congestive Heart failure 1 day.

Due to General Arterio Sclerosis 2 yrs

Other conditions.
(Include pregnancy within 3 months of death)

Major findings:
Of operations.

Of autopsy no

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).
(b) Date of occurrence.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury.

23. Signature H. F. Mundy M. D. or other
Address 404 S. 3rd St Date signed Sept 1-41

(Licensed Embalmer's Statement on Reverse Side)

ST. JOSEPH

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~or by~~

....., Registered Apprentice No.....
working under my personal supervision.

Signed

Geo E Daniel

Licensed Embalmer No. *3300*

P. O. Address

St Joseph Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.